Being paid the right amount for your services starts before a procedure is even performed. Scheduling, insurance verification, and precertification are all crucial to making sure your ambulatory surgery center (ASC) receives the proper reimbursement. Your surgery scheduler and insurance verification personnel need to know the key questions to ask so the right information is available for coding and billing. If steps are missed, claims can be denied.

The previous article covered scheduling issues. This article focuses on insurance verification and precertification.

Verifying the patient’s insurance
Verifying insurance benefits may seem basic. But it’s worthwhile to make sure your staff is covering these fundamentals.

- Be sure your facility verifies insurance benefits for every patient. Verify the information directly with the insurer. Make sure coverage will be in effect on the date of service.
- If the case is related to workers’ comp, call the appropriate carrier. Be sure to obtain all the payer’s requirements to ensure proper reimbursement.
- Determine the copayment and deductible.
- Obtain information about any secondary coverage the patient may have and verify that also.
- If your ASC is not a participating provider with the payor, find out the benefits for a nonparticipating provider. If the plan is an HMO, there may be no benefits for out-of-network providers, and your claim will be denied.
- Find out the payer’s payment policies for nonparticipating providers. If the check will be going to the insured, be sure you know that so you can arrange for the patient to sign the check over to the facility.
- Record all information in detail. Your ASC should have a form for this purpose. Document the name of the person at the payer’s office who verified the information, including the last name or at least the last-name initial. Don’t just write, “spoke to Debbie.” There may be 10 Debbies at that company.
- Have the front-desk staff copy the front and back of the patient’s insurance card and driver’s license (or the responsible party’s if different).

Is a precert needed?
When verifying the insurance, ask whether a precertification or authorization is required for the procedure being performed. Find out the correct phone number for the authorization, which may be different from the one on the patient’s insurance card.

Remember that obtaining the precertification does not mean the patient has insurance benefits and does not substitute for insurance verification. These authorizations are usually performed in a different part of the company or even by a separate company. Some additional tips on precertification:

- Inquire about authorization requirements for all of the procedures being performed,
not just the first procedure listed on the scheduling form. Even if an authorization isn’t required for the first procedure, it may be required for the second. If the question isn’t asked, part or all of the claim could be denied.

- If procedures originally scheduled or planned are not performed, or additional procedures are done that are not authorized on the front end, call the payor’s precertification department immediately after the surgery to inform them of the change. Many payors require notification within 24 hours after the procedure is performed if there is a change from the originally authorized procedure.

These are a couple examples of the types of precertification issues that can arise.

- The physician’s office schedules a case with the code for a diagnostic arthroscopy of the knee. But when the patient is in surgery, the physician discovers a tear of the lateral meniscus, for which he performs a lateral meniscectomy, and a tear of the medial meniscus, for which he performs a medial meniscectomy.

  Both procedures are billable with the 29880-LT code—which is different than the code for just a diagnostic arthroscopy. If the ASC checked with the payor at the time of scheduling and found a precertification was not required for the diagnostic arthroscopy of the knee, the facility needs to call back within 24 hours after surgery to inquire whether a precertification is required for the medial and lateral meniscectomies that were actually performed.

- A surgeon’s office schedules a gynecologic laparoscopy. But the surgeon actually performs a more extensive laparoscopic ablation of endometriosis procedure (code 58662), which is a different code from a diagnostic laparoscopy.

  Again, the facility should call within 24 hours after surgery to inquire whether a precertification is required for the ablation procedure actually performed.

“Claim denied”

These are some common oversights in preauthorization that can lead to your facility having a claim denied:

- The ASC relies on the physician’s office to obtain the precertification for a procedure—but the physician’s office didn’t obtain the precertification, so the facility’s claim is denied.

- The ASC relies on the physician’s office to obtain the precertification, and the physician’s office does so. But the office does not give the ASC the precertification number, and no one at the ASC follows up on it. The facility’s claim is denied.

- The ASC obtains a precertification number for the case but does not put the precertification number on the claim form. The facility’s claim is denied.

- The ASC does not obtain a precertification number for all of the procedures performed. The facility’s claim is denied.

- The ASC obtains the precertification and puts the precertification number on the claim form. But the claim is denied for “no precert obtained” or “no authorization obtained”—and the ASC does not fight the denial by providing proof to the payer that a precertification was obtained.

These are all ways ASCs can leave money on the table.

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